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For Whom the Bell (Equitably) Tolls: ERISA Compliance and Denial of Benefits Notices Circuit Split

Sarah Smith

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ABSTRACT

The circuit courts are split as to how a plan administrator of an ERISA-governed employee benefit plan must notify a claimant of a time limitation placed on a claimant's ability to seek judicial review of an adverse benefit decision. Some courts indicate that inclusion of this time limitation in the Summary Plan Description is sufficient to notify a claimant. Other courts have held that the time period must specifically be included in adverse determination notices, which are documents notifying claimants of the denial of their claim and the right to judicial review. Much of the debate among courts concerns the requirement of 29 C.F.R. § 2560.503-1(g)(1)(iv) that a benefits determination include a "description of the plan's review procedures and the time limits applicable to such procedures."

In this Article, I argue that the meaning of 29 C.F.R. § 2560.503-1(g)(1)(iv) is clear: the Plan-provided limitations period must be included in a final adverse benefits determination notice. Failure to disclose this information cannot be said to be in strict—or even substantial—compliance with the statute because such a failure would burden a claimant with no way to adequately remedy this burden. While claimants who have actual knowledge of the time limitation should be subject to the Plan's period of limitation even if it was not contained in the benefits

determination, a claimant that has simply received a Summary Plan Description should not be said to have constructive knowledge of the limitation period. The courts should treat a failure to disclose a limitation period in an adverse benefits determination notice as a waiver of the time limitation described in the Plan and instead apply an analogous state law statute of limitations, instead of tolling the limitations period set forth by the noncompliant Plan.

I. INTRODUCTION

The Employee Retirement Income Security Act of 1974 (ERISA) regulates employee welfare benefit plans.[1] Since the law's enactment, questions have been raised regarding the appropriate application of certain statutory provisions. This Article will consider the language contained in 29 C.F.R. § 2560.503-1(g)(1)(iv) and analyze the following issues: 1) when and how an ERISA governed welfare benefit plan (Plan) must provide claimants notice of the Plan's contractual limitations period for judicial review, and 2) when and how a claimant may seek judicial review if inadequate or no such notice is provided. There is considerable disagreement as to the interpretation of § 2560.503-1(g)(1)(iv), which provides that the adverse benefit determination must include: "A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review."[2]

The First, Third, and Sixth Circuit Courts of Appeals have recently held that an employer or Plan Administrator is in violation of the regulatory obligation if it fails to provide notice of the limitations period for review, regardless of the claimant's actual knowledge of the limitations period.[3] Furthermore, these courts held that if no such notice is provided to claimants in the denial of benefits notice, then the limitations period under the Plan will be waived and replaced with the limitations period provided by the most closely analogous state law claim,

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1. While many of the ERISA claim requirements apply to both welfare and pension plans, this Article will deal exclusively with welfare plans.

2. 29 C.F.R. § 2560.503-1(g)(1)(iv) (2018).

3. Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 129 (3d Cir. 2015); Santana-Díaz v. Metro. Life Ins. Co., 816 F.3d 172 (1st Cir. 2016); Moyer v. Metro. Life Ins. Co., 762 F.3d 503 (6th Cir. 2014).

as opposed to equitably tolling[4] the Plan's contractual limitations period.[5]

Disparately, the Second, Ninth, and Eleventh Circuits have not interpreted § 2560.503-1(g)(1)(iv) to require the contractual limitations period disclosure in the denial notice.[6] These circuits held that such limitations period notice is irrelevant if the claimant had actual notice of the limitations period, which may be imputed to the claimant by the receipt of a Summary Plan Description (SPD) or copy of the Plan Document.[7] In some cases, equitable tolling would be justified if the claimant had no actual knowledge of the limitations period and exercised diligence in pursuing his or her claim or was prevented from doing so by extraordinary circumstances.[8]

The Supreme Court's 2013 decision in *Heimeshoff v. Hartford Life & Accident Insurance Co.* (*Heimeshoff (2013)*) addressed the reasonableness of the Plan's contractual limitations periods, but it did not address other issues in these circuit split cases.[9] In light of the circuit split, this Article will explore the arguments on both sides of the issue and argue that the First, Third, and Sixth Circuits' arguments should govern because ERISA is clear on its face that notice of limitations is required in every adverse benefit determination. Furthermore, imputing the claimant with knowledge of the limitations period based upon receipt of the SPD is unfair to the claimant in cases where notice was provided out of context or buried in massive, esoteric Plan Documents. Finally, barring claimants

4. Black's Law Dictionary defines "equitable tolling" as:

> The doctrine that the statute of limitations will not bar a claim if the plaintiff, despite diligent efforts, did not discover the injury until after the limitations period had expired, in which case the statute is suspended or tolled until the plaintiff discovers the injury. . . . A court's discretionary extension of a legal deadline as a result of extraordinary circumstances that prevented one from complying despite reasonable diligence throughout the period before the deadline passed.

Equitable Tolling, BLACK'S LAW DICTIONARY (10th ed. 2014). I discuss the concept of equitable tolling as it relates to benefits claims further *supra* in Sections III and IV(D).

5. *Mirza*, 800 F.3d at 137; *Santana-Díaz*, 816 F.3d at 172.

6. Wilson v. Standard Ins. Co., 613 F. App'x 841 (11th Cir. 2015); Scharff v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899 (9th Cir. 2009); Heimeshoff v. Hartford Life & Accident Ins. Co., 496 F. App'x 129 (2d Cir. 2012), *aff'd*, 134 S. Ct. 604 (2013).

7. The Plan Document describes the Plan's administration process, types of benefits provided, and other required information. The Summary Plan Description (SPD) is an abbreviated summary of the Plan Document that must be provided to participants and must be written in a manner that is easily understood by the recipient. Certain information must be provided in the SPD, including the Plan name, contact information, eligibility requirements, and, of particular relevance to this Article, "[t]he procedures governing claims for benefits . . . , *applicable time limits*, and remedies available under the plan for the redress of claims which are denied in whole or in part . . . ." 29 C.F.R § 2520.102-3(s) (2018) (emphasis added).

8. *Wilson*, 613 F. App'x at 841; *Heimeshoff*, 496 F. App'x at 130-31.

9. Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 610 (2013).

from bringing claims after the Plan's contractual limitations period has run when the claimant was not provided the statutorily-required notice encourages Plans' noncompliance with ERISA.

Section II of this Article will explore the background of ERISA, providing context for § 2560.503-1(g)(1)(iv). This section will also provide a review of the claims procedure process and the particular terms of art relevant to the process as used by courts, legislatures, and practitioners. This information provides clarifying background necessary to supporting the conclusions set forth in Section IV.

Section III summarizes the courts' findings in prominent cases demonstrating the circuit split. The cases are reviewed and compared against one another, providing insight into the reasons for the circuit courts' conclusions. As Section III shows, even in cases with similar facts, the circuit courts reach different remedies for insufficient adverse determination notices.

Section IV analyzes the tools that the circuit courts used in reaching their interpretations of § 2560.503-1(g)(1)(iv) and concludes that if a claimant's denial notice does not contain the statutorily-required notice, the Plan's contractual limitations period should be set aside, instead applying the limitations period of the most closely analogous state cause of action.

II. ERISA AND THE CLAIMS PROCESS

ERISA is the federal law that governs most private-sector employee benefit Plans that are voluntarily established and maintained by an employer or employee organization.[10] ERISA does not apply to all Plans, generally excluding government Plans, church Plans, and "plans which are maintained solely to comply with workers' compensation, unemployment, or disability laws."[11] ERISA § 1001(b) indicates that the Act is intended to protect:

> [T]he interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate

10. Coverage, 29 U.S.C.S. § 1003(a) (LEXIS through Pub. L. No. 115-140).

11. *Health Benefits, Retirement Standards, and Workers' Compensation: Employee Benefit Plans*, DEP'T OF LABOR (updated Dec. 2016), https://webapps.dol.gov/elaws/elg/erisa.htm [https://perma.cc/3ZHJ-5G2R]; Coverage, 29 U.S.C.S. § 1003(b).

remedies, sanctions, and ready access to the Federal courts.[12]

ERISA was enacted to provide uniformity of rules application and protection to employees or former employees who are or will become eligible to receive benefits under a Plan (Participants).[13] This goal is not achieved when circuit courts inconsistently apply ERISA as discussed in Section III.

A. ERISA Broadly

ERISA covers two types of employee benefit plans: pension plans (also referred to as retirement plans), and welfare benefit plans (also known as health and welfare plans or group health plans, which typically provide medical and/or dental benefits).[14] ERISA does not require employers to provide employee benefits.[15] Once established, however, ERISA sets forth rules that a plan must follow. Each plan must have a Plan Sponsor and a Plan Administrator; often the employer fulfills both roles. The Plan Administrator is directly responsible for compliance with ERISA obligations and retains the legal liability for noncompliance.[16] ERISA plans must also name at least one fiduciary, either a person or an entity, who directs the plan's operation.[17] Others may act as fiduciaries for the plan, though not expressly named in the plan, with the defining factor being whether they exercise "discretion or control over the plan," including deciding participants' eligibility for benefits and determinations of claimants' appeals.[18]

Each plan must have a Plan Document, which describes the plan's administration process, types of benefits provided, and other important information. Instead of distributing this often lengthy document to all

12. Congressional findings and declaration of policy, 29 U.S.C.S. § 1001(b).

13. *See Health Plans & Benefits: ERISA*, DEP'T OF LABOR, https://www.dol.gov/general/topic/health-plans/erisa [https://perma.cc/9464-V8XM] (last visited Apr. 2, 2018); Definitions, 29 U.S.C.S. § 1002 (1).

14. *Id*.; *see also Glossary*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/ [https://perma.cc/NN3T-2N8K] (last visited Apr. 2, 2018).

15. DEIRDRE C. THOMAS, DARCY L. HITESMAN & NANCY A. STRELAU, EBIA BENEFITS LIBRARY: ERISA COMPLIANCE FOR HEALTH & WELFARE PLANS 7 (Thomson Reuters Checkpoint, 3rd qtr. ed. 2016).

16. *Id*. ("For single-employer plans, the employer-sponsor is usually the plan administrator because, unless someone else is designated in the documents governing a plan, ERISA provides that the plan administrator is the plan sponsor.").

17. *Understanding Your Fiduciary Responsibilities Under a Group Health Plan*, U.S. DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., 2 (Sept. 2015), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf [https://perma.cc/8D5P-F9JV].

18. *Id.*

participants and beneficiaries, a SPD that summarizes the Plan Document in a "manner understandable to the average plan participant" is required to be prepared and distributed to all participant and beneficiaries.[19] A SPD "must not have the effect of misleading, misinforming, or failing to inform participants and beneficiaries"; must explain any exceptions or other restrictions of plan benefits; and may be enforced over the Plan Document, if there is a discrepancy.[20] Additionally, and of particular importance to this Article, the SPD must include information about the plan's internal claims procedures and external review procedures.[21]

The Patient Protection and Affordable Care Act (PPACA) "establishes a new section 2719 of the [Public Health Services Act (PHSA)], which has been incorporated into ERISA and the Internal Revenue Code."[22] This new section, 29 C.F.R. § 2590.715-2719, adopts the ERISA internal claims and appeals requirements found in 29 C.F.R. § 2560.5301-1. In 2010, the Department of Health and Human Services, the Department of Labor (DOL), and the Department of Treasury issued interim final rules (IFR), which were later codified as 29 C.F.R. § 2590.715-2719 and became effective January 1, 2017.[23] IFR adopts the requirements of § 2560.503-1 and adds additional requirements relating to the internal and external benefits claim review.[24]

B. Enforcement of ERISA Through the EBSA

The DOL's Employee Benefits Security Administration (EBSA) is the "federal mechanism for enforcing the rights and duties" under ERISA.[25] Noncompliance with ERISA requirements may result in "DOL enforcement actions and penalty assessments or [through] employee lawsuits" in state or federal court under § 502(a):[26]

19. DEIRDRE C. THOMAS ET AL., *supra* note 15, at 14-15.

20. *Id.* The SPD must be updated and distributed to all participants every five years, or if there are no major changes, every ten years. *Id*. at 14.

21. *Id.* at 16 (stating that the SPD must also contain, inter alia: basic plan information, such as plan name, plan number, and the names of the plan sponsor and administrator; a description of the plan's eligibility rules; a description of the benefits the plan provides; "a statement clearly identifying circumstances that may result in loss or denial of benefits").

22. Memorandum from Jon Breyfogle and Julia Zuckerman, Groom Law Group, to Joel Slackman, *ACA Claims and Appeals Regulations* (Sept. 9, 2010) at 2, https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB45/00076.pdf [https://perma.cc/MA3H-YBCP] (last visited Apr. 2, 2018).

23. 29 C.F.R. § 2590.715-2719 (2018).

24. *Id*.

25. DEIRDRE C. THOMAS ET AL., *supra* note 15, at 2.

26. *Id*. at 2-3.

> When deciding disputes under ERISA, federal court judges have the power not only to interpret and apply ERISA to the facts but also to fill gaps in ERISA through creation of ERISA "federal common law." ERISA compliance obligations, not otherwise found in the statute or regulations, are increasingly being created by federal judges.[27]

ERISA compliance obligations are also shaped by final regulations set forth by EBSA.[28] Courts give great deference to these final regulations.[29] The DOL has also issued non-binding interpretive bulletins, Advisory Opinions, Information Letters, Technical Releases, Notices, FAQs, and Field Assistance Bulletins.[30]

C. The Claims Procedure Overview

ERISA sets forth notification and reporting regulations that govern the design and administration of retirement plans and welfare plans and provides remedies by which participants may bring claims for violations of these rules.[31] Except as specifically provided under the statute, every plan governed by ERISA must establish and maintain claims procedures, including the claims process and notification of claim determinations and the appeals process.[32]

There are two types of claims that can be brought under welfare plans: group health plan claims and disability claims.[33] Group health plan claims are claims for medical benefits, including emergency medical care or treatment, ongoing treatment, and other medical care requiring approval either before or after treatment.[34] Disability claims are similar to group health plan claims but require the claimant to establish that he or

27. *Id*. at 34 (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) and Sec. Life Ins. Co. of Am. v. Meyling, 146 F.3d 1184 (9th Cir. 1998)).

28. *Id*. at 32.

29. *Id*.

30. *Id*. at 32-33.

31. 29 U.S.C.S. § 1001 (LEXIS through Pub. L. No. 115-129); *see also* 26 C.F.R § 54.4980F-1 (WEST 2018) (effective Nov. 24, 2009).

32. 29 C.F.R. § 2560.503-1(a)(b) (2018); *see generally* Thomas G. Hancuch, Thomas G. Moukawsher & Eunice Washington, *Benefits Claims: A Primer on Claims Procedures and Benefit Claims Litigation*, THE AMERICAN BAR ASSOCIATION SECTION OF LABOR AND EMPLOYMENT LAW ANNUAL CLE CONFERENCE (Sept. 10-13, 2008), 3, http://www.americanbar.org/content/dam/aba/administrative/labor_law/meetings/2008/ac2008/078.authcheckdam.pdf [https://perma.cc/XYF4-5Z57].

33. Hancuch et al., *supra* note 32, at 3-4.

34. *Id*. These group health claims may include urgent care claims, concurrent care claims, pre-service care claims, and post-service care claims, respectively. *Id*.

she is disabled, as defined by the plan, in order to get a benefit, such as long-term disability benefits.[35]

PHSA § 2719 addresses the internal claims, appeals, and external review process of adverse benefit determinations.[36] Under the DOL's claims procedure regulation in 29 C.F.R. § 2560.503-1, adverse benefit determinations eligible for internal claims and appeals processes generally include a reason for "[a] denial, reduction, termination, or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits."[37] With the implementation of the PPACA, the definition of "adverse benefit determination" has been broadened to include rescissions of coverage.[38]

The specific benefits to which Participants are entitled are governed by the Plan Document created by the employer, subject to the provisions in 29 U.S.C. § 1104(a)(1)(D).[39] Generally, the Plan Administrator or insurance provider has the authority to approve or deny claims. In the event that a claimant's claim is denied, 29 U.S.C. § 1133 requires every employee benefit Plan to provide the claimant with certain information.[40] First, the Plan must provide written notice of the denial, including specific reasons for the denial "written in a manner calculated to be understood by the participant."[41] Second, the Plan must give a "reasonable opportunity . . . for a full and fair review" of the denial (which is referred to as an appeal).[42] The written notice is called a determination letter, a determination notice, or, as used throughout this Article, an adverse benefit determination.[43]

Title 29 U.S.C. § 1133 tasks the Secretary of Labor with creating the rules governing the claims procedure process.[44] In exercising that authority, the DOL issued extensive regulations in 29 C.F.R. § 2560.503-

35. *Id*. at 4.

36. Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. 72191(II)(D)(4), 77204 (Nov. 18, 2015) (to be codified at 26 C.F.R. § 54.9815-2712, 29 C.F.R. § 2590-2712, 45 C.F.R. § 147.128), https://www.federalregister.gov/d/2015-29294/p-139 [https://perma.cc/352E-VGHP] (last visited Apr. 2, 2018).

37. *Id*.

38. *Id*.

39. Hancuch et al., *supra* note 32, at 1.

40. Claims Procedure, 29 U.S.C.S. § 1133 (LEXIS through Pub. L. No. 115-140).

41. *Id.*

42. *Id.*

43. *See* Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 134-36 (3d Cir. 2015) (referring to the notice as an adverse benefit determination).

44. *Id.* at 133.

1, which sets forth the "minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries."[45] If a claimant's claim is ultimately denied in the internal appeals process, § 2560.503-1(g) dictates that the claimant receive a final adverse benefit determination, including, inter alia:

> (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review.[46]

Generally, participants must exhaust the Plan-provided internal review process before appealing to an external Independent Review Organization and must exhaust the internal and external review processes set forth by the Plan before bringing a civil action.[47] If, however, the Plan fails to comply with the claims regulations, a claimant may be considered to have exhausted the review process and file suit under ERISA § 502(a).[48]

The circuit courts agree, and the Supreme Court confirms, that ERISA itself does not contain a statute of limitations period for bringing a civil action, and Plans may impose their own limitations period that will govern as long as it is reasonable.[49] If a Plan fails to provide such a limitations period, the federal courts may "borrow the most closely analogous statute of limitations in the forum state."[50] Typically, the limitations period starts to run upon notice of the final denial, unless the Plan Document states otherwise.[51] If the Plan fails to follow the ERISA

45. 29 C.F.R. § 2560.503-1(a) (2018).

46. *Id.* § 2560.503-1(g)(iv) (2018).

47. DEIRDRE C. THOMAS ET AL., *supra* note 15, at 22.

48. *Id.*; *see generally* Peter K. Stris & Victor O'Connell, ERISA & Equity, 29 ABA J. of Lab. & Emp. L. (Fall Issue 1), 125-43 (2013). Participants may also bring a civil action under section 502(a) for benefits due under the plan, for recovery of benefits from a breaching fiduciary, and/or to obtain other appropriate equitable relief. *See* 29 U.S.C.S. § 1132(a)(1), (3) (LEXIS through Pub. L. No. 115-140); *see generally* DEIRDRE C. THOMAS ET AL., *supra* note 15.

49. *See generally* Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 134 (3d Cir. 2015); Moyer v. Metro. Life Ins. Co., 762 F.3d 503 (6th Cir. 2014); Santana-Díaz v. Metro. Life Ins. Co., 816 F.3d 172 (1st Cir. 2016); Heimeshoff v. Hartford Life & Accident Ins. Co., 496 F. App'x 129 (2d Cir. 2012), *aff'd*, S. Ct. 604 (2013); Scharff v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899 (9th Cir. 2009); Wilson v. Standard Ins. Co., 613 F. App'x 841 (11th Cir. 2015); *see also* Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 610 (2013) ("Absent a controlling statute to the contrary, a participant and a Plan may agree by contract to a particular limitations period, even one that starts to run before the cause of action accrues, as long as the period is reasonable.").

50. Santaliz-Ríos v. Metro. Life Ins. Co., 693 F.3d 57, 59 (1st Cir. 2012).

51. "As a general matter, a statute of limitations begins to run when the cause of action 'accrues'—that is, when 'the plaintiff can file suit and obtain relief.'" *Heimeshoff*, 134 S. Ct. at 610 (quoting Bay Area Laundry and Dry Cleaning Pension Trust Fund v. Ferbar Corp. of Cal., 522 U.S. 192, 201 (1997)).

claims procedures, a court may consider the claimant to have exhausted the available reviews under the Plan, and thus the claimant is entitled to bring suit.[52]

The standard of review, in any case, determines the extent to which the court may interpret the Plan Document and evaluate the fiduciaries' decisions. Unless the Plan Document states that the more deferential abuse of discretion standard of review applies, the court reviews cases under the de novo standard, allowing the court to decide for itself "[w]hat plan terms mean and how factual issues should be resolved."[53] Even under the abuse of discretion standard, the court considers the extent to which the Plan decision-maker has a conflict of interest.[54]

III. CIRCUIT COURT SPLIT ON FAILURE TO PROVIDE NOTICE OF RIGHT TO JUDICIAL REVIEW

As noted above, there is a consensus that a Plan can provide its own limitations period and that courts can apply analogous state law limitations when the Plan does not provide its own. However, there remains disagreement as to whether of 29 C.F.R. § 2560.503-1(g)(1)(iv) requires that the limitations period must also be provided in the final benefits determination or need only be provided in the SPD.[55] If the statute is violated, courts then consider whether the limitations period is equitably tolled or whether the Plan effectively waived the limitations period. There is also a split within the courts as to the effect of actual or constructive notice on final benefits determination notice that does not provide the Plan-provided limitations period.[56]

52. Hancuch et al., *supra* note 32, at 10.

53. DEIRDRE C. THOMAS ET AL., *supra* note 15, at 11.

54. *Id*.

55. 29 C.F.R. § 2560.503-1(g)(1)(iv) (2018): A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review.

56. Some courts that have held that a final determination notice that fails to provide the plan-provided limitations period effectively waives the limitations period have declined to determine whether the final determinations notice must list, in the absence of a plan-provided limitations period, the limitations period that would apply (i.e. the statute of limitations provided by the most closely analogous state law). *See* Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 129, 136 (3d Cir. 2015). While the courts have frequently found state contract law or insurance law to be most closely analogous, some parties to relevant litigation have suggested that this would place Plan Administrator in the precarious position of researching the applicable laws from state to state and provide this legal advice to the participants. The courts in both *Mirza* and *Santana-Diaz* decline to extend the time-limit notice rule to plans that do not set a different time limit. *Id.*

A. Three Circuit Courts Find Noncompliance to Eliminate Plan-Provided Limitations Period

Three circuit courts have ruled that if a Plan fails to comply with ERISA's notice of contractual limitations period in a denial of benefits notice, a participant may bring judicial review after the contractual limitations period has run even if the claimant had actual or constructive knowledge of the limitations period. Additionally, these three circuits agree that, while strict compliance with § 2560.503-1 is not required, an adverse determination notice must *substantially* comply with the statute. Failure to include the Plan-provided limitations period does not substantially comply with the requirements of § 2560.503-1. Remarkably, none of these cases apply equitable tolling but instead act as if the Plan did not provide a limitations period and borrow from the most analogous state law.

1. Third Circuit: *Mirza v. Insurance Administrator of America, Inc*.

In *Mirza v. Insurance Administrator of America, Inc.*, the claimant assigned her benefits to her two treating physicians' offices, Dr. Neville Mirza and Spine Orthopedic Sports (Spine), both of whom had the same legal counsel, Callagy Law.[57] Mirza exhausted the internal review process and received a final benefits determination notice on August 12, 2010, which mentioned that she had the right to seek judicial review but failed to mention that there was a Plan-provided limitations period.[58] On November 23, 2010, a representative of Callagy Law spoke with the insurance provider in relation to Spine's claim. During this phone conversation, the insurance provider claims to have stated that the one-year limitations period ran from the date of the final denial.[59] Callagy Law then requested a copy of the Plan Document, still in relation to Spine's partial benefits denial, and received it on April 11, 2011, just four months before Mirza's limitations period expired.[60] The Plan Document provided that claimants had a one-year limitations period to seek judicial review after the final benefits determination notice was decided.[61] Mirza brought

57. *Id.* at 131.
58. *Id*.
59. *Id.* at 131-32.
60. *Id.* at 132.
61. *Id.* at 130.

suit, to which Spine was not a party, seeking review of the denied benefits claim.[62]

The district court found that Mirza was not entitled to equitable tolling because Mirza had notice of the one-year limitations period, imputing Callagy Law's knowledge to Mirza because Callagy Law represented the same claimant under the same Plan Document.[63] On appeal, the Third Circuit reversed, finding that 29 C.F.R. § 2560.503-1(g)(1)(iv) requires Plan Administrators to inform claimants about the time limitations period for bringing a civil action and that the remedy for this notice failure is to "[s]et aside the plan's time limit and apply the limitations period from the most analogous state-law cause of action."[64] Because the denial letter did not comply with this notice requirement, the one-year deadline for judicial review set by the Plan was not enforceable.[65] Thus, Mirza's suit was timely as it was brought within the six-year New Jersey limitations period for breach of contract.[66]

The Third Circuit reached this decision by interpreting 29 C.F.R. § 2560.503-1(g)(1)(iv) to require the inclusion of the Plan-provided time limit in an adverse benefit determination, careful to apply this provision only to Plans that set a limitations period and not to Plans that are simply silent and by default borrow from analogous state law.[67] The Third Circuit also noted that allowing a Plan Administrator to argue that the claimant had actual notice would encourage the Plan Administrators to "hide the ball" by hiding the limitations period in the lengthy Plan Document and not disclose it in the denial notice, as required by C.F.R. § 2560.503-1(g)(1)(iv).[68]

2. First Circuit: *Santana-Diaz v. Metropolitan Life Insurance Co.*

In *Santana-Diaz v. Metropolitan Life Insurance Co.*, Santana-Diaz, the claimant, went on long-term disability for "[m]ajor depression, high blood pressure, asthma, and various other physical and mental ailments."[69] After almost a year and a half on long-term disability, MetLife, the insurance provider, informed him that the Plan only allowed for 24 months of long-term disability for mental disabilities like his

62. *Id.* at 131.
63. *Id.* at 132.
64. *Id.* at 131.
65. *Id.* at 138.
66. *Id.*
67. *Id.* at 136.
68. *Id.* at 135.
69. Santana-Díaz v. Metro. Life Ins. Co., 816 F.3d 172, 175 (1st Cir. 2016).

pursuant to the Plan, and that unless he could show documentation that he was not subject to this limitation, further benefits would be denied.[70] He submitted further documentation but was denied an extension beyond the 24 months.[71] He appealed, but his claim was again denied.[72] When he had first become an employee, his employer gave him a copy of the Plan Document, which stated there was a three-year limitations period for bringing suit.[73] Both denial notices said he could bring civil action but failed to include the limitations period or mention that there was a limitations period.[74]

The district court dismissed his suit as time-barred.[75] On appeal, he argued it should be equitably tolled as MetLife did not include a time period for filing suit in its denial of benefits letter.[76] The First Circuit, like in *Mirza*, did not reach the issue of equitable tolling and instead disposed of the case on other grounds.[77] Because MetLife did not substantially comply with § 2560.503-1(g)(1)(iv), the appropriate remedy was to apply the state's most closely analogous limitations period, not the Plan's limitations period.[78]

Unlike the Third Circuit in *Mirza*, the First Circuit in *Santana-Diaz* required the plaintiff to show that the violation prejudiced him by showing how proper notice "would have made a difference."[79] Ultimately, the First Circuit found that failure to include the required notice was per se prejudicial to the claimant, and thus, the limitations period was altogether inapplicable.[80] It reached its decision using the same logic as the *Mirza* court, even quoting the decision.[81] To hold otherwise, the First Circuit argued, would be against the purpose of ensuring a fair opportunity to judicial review and would "'[r]ender hollow the important disclosure function of § 2560.503-1(g)(1)(iv),' as Plan Administrators would then

70. *Id*.
71. *Id*.
72. *Id*.
73. *Id*.
74. *Id*.
75. *Id.* at 176.
76. *Id.*
77. *Id.* at 178.
78. *Id*. at 174 ("Because MetLife violated this regulatory obligation, the limitations period in this case was rendered inapplicable.").
79. *Id*. at 182 (citing Recupero v. New England Tel. and Tel. Co., 118 F. 3d 820, 840 (1st Cir. 1997)).
80. *Id*.
81. *Id*. at 180.

'have no reason at all to comply with their obligation to include contractual time limits for judicial review in benefit denial letters.'"[82]

In discussing the policy behind its ruling, the First Circuit argued that claimants are more likely to read the time limit if it is in the final denial letter as opposed to being buried in the Plan Document given to the claimant—possibly years earlier—which is why the DOL requires that specific information be included in the denial letters.[83] The First Circuit argued that Plan Administrators should not be able to avoid this inclusion simply because the claimant had received the Plan Document at some point.[84] To do so, the *Santana-Diaz* court reasoned, would "[e]ffectively make § 2560.503-1(g)(1)(iv) a 'dead letter.'"[85]

3. Sixth Circuit: *Moyer v. Metropolitan Life Insurance Co*.

In *Moyer v. Metropolitan Life Insurance Co.*, MetLife initially approved Moyer's claim but reversed the decision two years later once it determined that "Moyer retained the physical capacity to perform work somewhere other than his former job."[86] As in *Mirza* and *Santana-Diaz*, Moyer's final benefits determination notice included notice of the right to judicial review, but it failed to specify that the Plan had a three-year contractual time limit.[87] The SPD, which was provided to Participants, "[f]ailed to provide notice of either Moyer's right to judicial review" or the time limit.[88] Moyer's Plan Document did state the time limit but, as allowed by ERISA, it was not sent to Participants unless requested.[89] Nevertheless, the district court found for MetLife, concluding that "MetLife provided Moyer with constructive notice."[90] Moyer appealed, requesting that the court apply equitable tolling in allowing him to bring his claim beyond the three-year contractual limitations period.[91] The Sixth Circuit remanded the case and noted that "'[a] notice that fails to substantially comply with these [§ 1133] requirements does not trigger a time bar contained within the plan.'"[92]

82. *Id*. at 184 (citing Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 129, 137 (3d Cir. 2015)).
83. *Id*. at 181.
84. *Id*. at 184.
85. *Id*.
86. Moyer v. Metro. Life Ins. Co., 762 F.3d 503, 504 (6th Cir. 2014).
87. *Id*.
88. *Id*.
89. *Id*.
90. *Id*.
91. *Id*.
92. *Id*. at 507 (citing Burke v. Kodak Ret. Income Plan, 336 F.3d 103, 107 (2d Cir. 2003)).

Unlike in *Mirza* and *Santana-Diaz*, one judge dissented with the majority's decision, reasoning that Moyer's argument that the notice was deficient did not specifically mention 29 C.F.R. § 2560.503-1, and thus the court should not address it.[93] The majority disagreed, finding that raising the broad issue of notice was enough for the court to evaluate the notice requirements of 29 C.F.R. § 2560.503-1.[94] The dissent further argued that even if it was permitted to review 29 C.F.R. § 2560.503-1, the exclusion still constituted substantial compliance with the statute, and thus the Plan's limitations period should apply.[95] As the dissenting opinion points out, "courts elsewhere split on whether the regulation requires a claim-denial letter to inform a participant of *both* their right to bring a civil action *and* the action's limitations period."[96]

4. Sixth Circuit: *Engleson v. Unum Life Insurance Co. of America*

Though not part of the circuit split, *Engleson v. Unum Life Insurance Co. of America* provides important insights into the Sixth Circuit's decisions and perfectly summarizes the change in claims procedure notice requirements that took effect January 1, 2002.[97] Claimant Engleson's final denial notice did not include the limitations notices required by the Plan, and he brought his claim after the contractual limitations period.[98] The Sixth Circuit found for the insurance company, stating:

> Engleson suffers from unfortunate timing . . . . Had these events transpired a year later, he would have a colorable ERISA violation. But the civil action notice was not required until 2002, having been enacted in 2000. *See* 29 C.F.R. § 2560.503-1(*o*) (2001) (indicating that the regulations would take effect on January 1, 2002). *Compare* 29 C.F.R. § 2560.503-1(f)(4) (2000) (requiring "[a]ppropriate information as to the steps to be taken if the participant . . . wishes to submit his . . . claim for review"), *with* 29 C.F.R. § 2560.503-1(g)(1)(iv) (2001) (requiring plans to include "a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action" to challenge adverse benefit determinations). . . . We conclude that Unum was under no regulatory obligation in 2001 to disclose either Engleson's right to pursue litigation in federal court or the limited window for obtaining

93. *Id.* at 508 (Cook, J., dissenting).
94. *Id.* at 505.
95. *Id*. at 509 (Cook, J., dissenting).
96. *Id.* at 508.
97. *See generally* Engleson v. Unum Life Ins. Co. of Am., 723 F.3d 611 (6th Cir. 2013).
98. *Id.*

such review in its claim denial letter.[99]

The court previously referenced the 2000 edition of the Code of Federal Regulations:

> (f) *Content of notice*. A plan administrator . . . shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:
>
> . . . .
>
> (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.[100]

The law had changed by the time Engleson brought his claim, but the court applied the law as it was when his claim accrued[101] and held to the contrary of what it would later hold in *Moyer*.[102] The Sixth Circuit reviewed Engleson's claim[103] and ultimately declined to apply equitable tolling or set aside the Plan's limitations period.[104]

B. Circuit Courts Finding Actual Notice Meets ERISA Notice Requirements

Three other circuit court cases have found that exclusion of the Plan's contractual limitations period is not enough to trigger equitable tolling. Each court held either that notice of a Plan's contractual limitations period is not required to be disclosed in a denial notice, or have refused to apply equitable tolling because Participants had actual notice of the limitations period from a separate notice.

1. Eleventh Circuit: *Wilson v. Standard Insurance Co.*

In *Wilson v. Standard Insurance Co.*, the claimant, Wilson, appealed the district court's grant of summary judgment for the insurance company on the basis that her claim was time-barred by the contractual limitations

99. *Id*. at 618-19.

100. *Id*. at 617 (citing the 2000 Code of Federal Regulations).

101. *Id*. at 613.

102. *Id*. at 624; *see* Moyer v. Metro. Life Ins. Co., 762 F.3d 503, 504 (6th Cir. 2014).

103. The court applied a five-part equitable tolling test to render its decision: "'(1) lack of actual notice of filing requirement; (2) lack of constructive knowledge of filing requirement; (3) diligence in pursuing one's rights; (4) absence of prejudice to the defendant; and (5) a plaintiff's reasonableness in remaining ignorant of the notice requirement.'" *Id.* at 623 (citing Longazel v. Fort Dearborn Life Ins. Co., 363 F. App'x 365, 368 (6th Cir. 2010)).

104. *Engleson*, 723 F.3d at 611.

period provided by the Plan Document.[105] Wilson was denied long-term disability benefits, appealed, and exhausted the internal review process resulting in a final benefits determination notice.[106] The notice failed to note the contractual limitations period provided by Wilson's Plan.[107] She filed 34 months after the three-year limitations period given by the policy.[108] In her appeal, Wilson pled that the limitations period be equitably tolled.[109]

Though the Supreme Court previously ruled on a similar issue in *Heimeshoff (2013),*[110] the Eleventh Circuit concluded that the issue was not resolved in that "*Heimeshoff* left open the possibility that equitable tolling 'may apply,' but only '[t]o the extent the participant has diligently pursued both internal review and judicial review but was prevented from filing suit by extraordinary circumstances.'"[111] Wilson argued that the court should not have even considered whether she was diligent in pursuing a claim because the Plan's noncompliance with §2560.503-1(g)(1)(iv) did not afford her the full and fair review to which she was entitled under 29 U.S.C. § 1133.[112] The Eleventh Circuit finally concluded that the full and fair review requirement of § 1133 applied only to the review by the appropriate named fiduciary.[113]

Unlike the courts in *Moyer*, *Mirza*, and *Santana-Diaz*, the Eleventh Circuit found 29 C.F.R. § 2560.503-1(g)(1)(iv) to be "anything but clear."[114] The Eleventh Circuit went on to find that even if it construed the statute in Wilson's favor, it would not fault the insurance company for interpreting it differently.[115] Thus, Wilson was required to show extraordinary circumstances and diligence in pursuing her claim. Although the insurance company's denial notice excluded the time period for appeal, it "did alert Wilson that it would provide 'copies of all documents, records and other information relevant to [her long-term disability] claim free of charge.'"[116] The Eleventh Circuit found that this was sufficient notice to prompt Wilson to investigate the claims process,

105. Wilson v. Standard Ins. Co., 613 F. App'x 841, 842 (11th Cir. 2015).
106. *Id.*
107. *Id*.
108. *Id*.
109. *Id.*
110. Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604 (2013). Discussed *infra* Section III(C).
111. *Wilson*, 613 F. App'x at 843 (citing *Heimeshoff*, 134 S. Ct. 604).
112. *Id*.
113. *Id*.
114. *Id*. at 844.
115. *Id*.
116. *Id*. at 845.

and that Wilson did not exercise even "minimal diligence in discovering the terms of the policy."[117]

2. Ninth Circuit: *Scharff v. Raytheon Co. Short Term Disability Plan*

In *Scharff v. Raytheon Co. Short Term Disability Plan*, the claimant, Scharff, received a final denial notice directing her to review the procedures in the SPD, which mentioned the one-year limitations period and had been provided to her upon hire.[118] The final denial notice told her of her right to file suit in federal court but did not expressly mention that time limit.[119] Scharff brought suit after her short-term disability claim was denied—20 days after the one-year limitations period set by the Plan.[120] The district court dismissed the case as untimely.[121]

On appeal, Scharff fatally conceded "that the Plan met all applicable ERISA disclosure requirements and that MetLife was not obligated under ERISA to inform her of the deadline."[122] She chose instead to ask the court to apply the reasonable expectations doctrine.[123] The Ninth Circuit assumed—without affirmatively deciding—that the reasonable expectations doctrine applied, with the deciding factor being "whether the deadline was 'written in a manner calculated to be understood by the average plan participant.'"[124] The Ninth Circuit concluded that the time limit was not buried in the document, was easily accessible, and met the notice requirements.[125]

In the alternative, Scharff asked the court to incorporate the California Code of Regulations requiring insurers to disclose any time limits that may apply to the claim, but the Ninth Circuit declined to adopt such requirements into federal common law and affirmed the dismissal.[126] Unlike the previous cases reviewed in this Article, *Scharff* did not discuss 29 C.F.R. § 2560.503-1(g)(1)(iv) and its ambiguity.[127] Instead, it

117. *Id*. at 845-46.
118. Scharff v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899, 902 (9th Cir. 2009).
119. *Id*. at 902-03.
120. *Id*. at 902.
121. *Id*. at 903.
122. *Id*. at 907.
123. *Id*. at 903 (citing 29 U.S.C.S. § 1022(a)) (LEXIS through Pub. L. No. 115-140).
124. *Id*. at 906.
125. *Id*. at 907.
126. *Id*. at 902.
127. *See id.*

implicitly assumed the time limit disclosure requirements could be met by disclosure in the SPD.[128]

3. Second Circuit: *Heimeshoff v. Hartford Life & Accident Insurance Co.*

In *Heimeshoff v. Hartford Life & Accident Insurance Co.*, Heimeshoff filed for long-term disability benefits under her employer's group health plan but her claim was denied.[129] She obtained counsel but was informed by Hartford "'[t]hat no formal appeal was necessary and that if Hartford received clarification of Heimeshoff's functionality, the insurance company would re-open the claim.'"[130] The Plan set the limitations period for taking legal action at three years from the "'[t]ime written proof of loss is required to be furnished according to the terms of the policy.'"[131] The district court concluded that 29 C.F.R. § 2560.503-1(g)(1)(iv) unambiguously does not require a statement of the time limits applicable to bring a civil action; it dismissed her claim as time barred, concluding Heimeshoff filed her claim two months too late.[132]

On appeal, Heimeshoff argued that the Plan's "[l]imitations period did not begin to run until the final denial of benefits."[133] The Second Circuit disagreed.[134] Heimeshoff also reasserted her argument that Hartford was required by 29 C.F.R. § 2560.503-1(g)(1)(iv) to disclose the time limit for bringing a civil action and pled that "[f]ailure to do so entitled [her] to equitable tolling."[135] The Second Circuit decided it need not address that issue because Heimeshoff's counsel conceded that before the limitations period expired he had received a copy of the Plan Document containing the limitations period.[136]

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128. *Id.* at 906.

129. Heimeshoff v. Hartford Life & Accident Ins. Co., No. 3:10cv1813 (JBA), 2012 U.S. Dist. LEXIS 6882, at *1, 4-2 (D. Conn. Jan. 16, 2012), *aff'd*, 496 F. App'x 129 (2d Cir. 2012), *aff'd*, 134 S. Ct. 604 (2013).

130. *Id*.

131. *Id*. at *7.

132. *Id*. at *13-16.

133. Heimeshoff v. Hartford Life & Accident Ins. Co., 496 F. App'x 129, 130 (2d Cir. 2012), *aff'd*, 134 S. Ct. 604 (2013).

134. *Id.* ("Here, Connecticut's six-year statute of limitations applicable to contract actions applies, Conn.Gen.Stat. § 52-576, while federal law controls the accrual date of the party's claim. . . . Under Connecticut law, parties to an insurance contract may shorten the statute of limitations period to not less than one yearFalse In this Circuit, a statute of limitations specified by an ERISA plan for bringing a claim under 29 U.S.C. § 1132 may begin to run before a claimant can bring a legal action.").

135. *Id*.

136. *Id*.

C. Relevant United States Supreme Court Decisions

Heimeshoff appealed to the Supreme Court, which "[g]ranted certiorari to resolve a split among the Courts of Appeals on the enforceability of this common contractual limitations provision."[137] The Court addressed whether the Plan's contractual limitations provisions were enforceable.[138] The Supreme Court ultimately affirmed the Second Circuit's decision holding that the Plan's limitations provision was enforceable.[139] While the Supreme Court did not discuss what action is appropriate when a Plan fails to comply with ERISA's notice requirement of § 2560.503-1(g)(1)(iv), the Court's decision offers other relevant insight into the ERISA claims process and the policy supporting the statutory requirements.

IV. THE ARGUMENTS FOR AND AGAINST INTERPRETING 29 C.F.R. § 2560.503-2(G)(1)(IV) TO MANDATE NOTICE OF JUDICIAL REVIEW AVAILABILITY IN THE DETERMINATION NOTICE

The uniformity of decisions is crucial for Plan Administrators; without clear direction, Plan Administrators and fiduciaries may be held liable for noncompliance.[140] This is especially important for multistate employers who may be subject to different common law rules from different circuits in which they operate.[141] Moreover, "'Congress expects uniformity of decisions under ERISA.'"[142] The circuit split on the interpretation of 29 C.F.R. § 2560.503-1(g)(1)(iv) is directly contrary to this directive. The Supreme Court decision in *Heimeshoff (2013)* leaves ambiguity as to the interpretation of the statute; four of the six circuit split decisions discussed above took place after the Court's ruling in *Heimeshoff (2013)*.[143]

137. Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 610 (2013). "We granted certiorari to resolve a split as between. . . . Burke [v. PriceWaterHouseCoopers LLP Long Term Disability Plan, 572 F. 3d 76, 79-81 (CA2 2009)] (plan provision requiring suit within three years after proof-of-loss deadline is enforceable); and Rice v. Jefferson Pilot Financial Insurance Co., 578 F.3d 450, 455-456 (CA6 2009) (same), with White v. Sun Life Assurance Co. of Canada, 488 F.3d 240, 245-248 (CA4 2007) (not enforceable); and Price v. Provident Life & Acc. Insurance Co., 2 F.3d 986, 988 (CA9 1993) (same)." *Heimeshoff*, 134 S. Ct. at 610.

138. *Heimeshoff*, 134 S. Ct. at 608.

139. *Id*. at 605.

140. Scharff v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899, 908 (9th Cir. 2009).

141. *Id*.

142. *Id*. (citing Evans v. Safeco Life Ins. Co., 916 F.2d 1437, 1440 (9th Cir. 1990) (per curiam)).

143. Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 129 (3d Cir. 2015); Santana-Díaz v. Metro. Life Ins. Co., 816 F.3d 172 (1st Cir. 2016); Moyer v. Metro. Life Ins. Co., 762 F.3d 503 (6th Cir. 2014); Wilson v. Standard Ins. Co., 613 F. App'x 841 (11th Cir. 2015).

A. Interpretation of 29 C.F.R. § 2560.503-1(g)(1)(iv)

There is very little legislative or regulatory guidance on the interpretation of § 2560.503-1(g)(1)(iv). The PPACA added new requirements in the IFR, effective September 21, 2010, which were in effect for all the cases discussed above, except *Scharff*.[144] The IFR of 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E) have since been adopted into the final regulations, effective January 1, 2017.[145] Neither the interim rules nor the final rules clarify the requirements of § 2560.503-1(g), but they reiterate that notice requirements must be complied with: "A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner . . . that complies with the requirements of 29 C.F.R. § 2560.503-1(g) and (j)."[146]

The final rules go on to list additional requirements, including that "[t]he plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal."[147] Adding such requirements emphasizes the importance of making the internal and external review procedures available to a claimant who has been denied benefits. Even if it is not expressly required, the initiation of an appeal necessarily includes the time limit for bringing the appeal. Logically, the process would entail detailing who, when, where, and how. Without all these parts, the claimant would be making decisions without knowing all the pertinent details. For first-time claimants, the process is unfamiliar with few resources known to them. It is confusing and riddled with unfamiliar medical terminology and codes. Claimants are likely to be overwhelmed and emotional as these decisions directly impact their health, wellbeing, and often income. In some circumstances, the outcome of the appeals decision can foreseeably affect them the rest of their lives.

144. *See generally* Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 Fed. Reg. 43330 (proposed July 23, 2010) (codified at 26 C.F.R. 54, 26 C.F.R. 602, 29 C.F.R. 2590, 45 C.F.R. 147), https://www.gpo.gov/fdsys/pkg/FR-2010-07-23/pdf/2010-18043.pdf [https://perma.cc/3PUU-Z3PA] (last accessed Feb. 25, 2017).

145. Internal claims and appeals and external review processes, 29 C.F.R. § 2590-2719(b)(2)(ii)(E).

146. *Id*.

147. *Id.* § 2590-2719(b)(2)(ii)(E)(4).

1. Courts' Interpretations Favoring the Inclusion of the Limitations Period Disclosure

Without further statutory or regulatory guidance, courts are left to their own interpretations, creating disunity. Consider again the language of 29 C.F.R. § 2560.503-1(g)(1)(iv):

> The notification shall set forth, in a manner calculated to be understood by the claimant . . . (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review.[148]

In *Mirza*, the parties disagreed as to the interpretation of 29 C.F.R. § 2560.503-1(g)(1)(iv). Mirza argued that, "[a] claimant's 'right to bring a civil action' . . . is one of the 'review procedures' for which 'time limits' must be disclosed."[149] The insurance company argued that the statute requires two distinct requirements, dividing the sentence at the comma into: "[n]otice of the plan's review procedures and applicable time limits for those procedures" and "'[n]otice of the right to sue."[150] To come to this conclusion, the word "including" must be ignored or lose its meaning.

However, as the Supreme Court has recognized, "[i]t is 'a cardinal principle of statutory construction' that 'a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant.'"[151] If a statute can be interpreted so as to avoid surplusage, it should.[152] Furthermore, punctuation alone is rarely sufficient to sustain or contradict an interpretation.[153] In light of these rules of statutory interpretation, the meaning of 29 C.F.R. § 2560.503-1(g)(1)(iv) is clear: notice of the Plan's review procedures necessarily includes notices of the application limitations period.

The *Mirza* court disagrees with the insurance company, finding that "including" is the most important word and that it modifies the word "description": "If the description of the review procedures must 'includ[e]' a statement concerning civil action, then civil actions are

148. 29 C.F.R. § 2560.503-1(g)(1)(iv).

149. Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 129, 134 (3d Cir. 2015).

150. *Id.*

151. TRW Inc. v. Andrews, 534 U.S. 19, 31 (2001) (citing Duncan v. Walker, 533 U.S. 167, 174 (2001)).

152. *See* LISA SCHULTZ BRESSMAN, EDWARD L. RUBIN & KEVIN M. STACK, THE REGULATORY STATE 282 (Wolters Kluwer 2d ed. 2013).

153. *Id.* at 271.

logically one of the review procedures envisioned by the Department of Labor. And as with any other review procedure, the administrator must disclose the plan's applicable time limits."[154] The court went on to argue that a broad interpretation is preferred because ERISA is a remedial statute.[155] This interpretation is more consistent with modern principles of statutory interpretation.[156]

In *Santana-Diaz*, the First Circuit, like the Third Circuit Court in *Mirza*, finds the word "including" in 29 § C.F.R. 2560.503-1(g)(1)(iv) to be pivotal, and ultimately decided, like the Third Circuit, that the meaning is clear: the statute requires the time limit for filing suit to be provided for both the Plan's review procedures and for judicial review.[157] In discussing the policy behind their ruling, the First Circuit cites *Aetna Health Inc. v. Davila*,[158] which found ERISA to be a remedial statute intended "[t]o 'protect . . . the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal Courts.'"[159] Failing to provide notice of an applicable limitations period, however, protects the interests of the employer.

Furthermore, 29 U.S.C. § 1133 provides that claimants whose claims have been denied benefits should be "afford[ed] a reasonable opportunity . . . for a full and fair review by the appropriate named fiduciary."[160] The First Circuit held the purpose of this is to "enable the claimant to prepare adequately for any further administrative review, as well as appeal to the federal courts."[161]

2. Courts' Interpretations Not Requiring the Limitations Period Disclosure

In *Wilson*, the Eleventh Circuit interpreted § 2560.503-1(g)(1)(iv) to "[c]learly require that a claims denial letter include notice about the administrative review procedures and the time limits for filing that apply to those procedures as well as the fact that the claimant has a right to bring

154. *Mirza*, 800 F.3d at 134.

155. *Id*. at 135.

156. *See* BRESSMAN ET. AL, *supra* note 152, at 270-83.

157. Santana-Díaz v. Metro. Life Ins. Co., 816 F.3d 172, 179-80 (1st Cir. 2016).

158. *Id*. at 179.

159. Aetna Health Inc. v. Davila, 546 U.S. 200, 208 (2004) (citing 29 U.S.C.S. § 1001(b) (LEXIS through Pub. L. No. 115-140)) (alteration in original).

160. Claims Procedure, 29 U.S.C.S. §1133(2) (LEXIS through Pub. L. No. 115-140).

161. *Santana-Díaz*, 816 F.3d at 179 (citing Witt v. Metro. Life Ins. Co., 722 F.3d 1269, 1280 (11th Cir. 2014)).

a civil action under § 502(a) of ERISA."[162] The Eleventh Circuit goes on to say that interpreting a lawsuit as part of the Plan's review process is a "strained reading."[163]

Perhaps supporting this interpretation is the fact that the template for final benefit determination notices, published by EBSA, does not expressly include a disclosure of the limitations period.[164] The model document contains a provision stating:

> If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit. Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information].[165]

While this language does provide boilerplate language for the notice, it is not sufficient on its own. The Plan Administrator must fill out most of the notice with the claimant's particular appeal facts, and Plan provisions presumably include the time-period set forth by the Plan. In any case, statutory language is authoritative and binding; sample language from EBSA is not. The Plan Administrator must be familiar with the applicable laws and apply them appropriately.[166]

The Eleventh Circuit failed to consider that the Plan can set the time limit for bringing a lawsuit. While the suit would not be part of the Plan's review process, in that the review is done by an external reviewer, the Plan still exercises control over the time limit for bringing suit, making it part of the review process.

B. Strict versus Substantial Compliance

Assuming that § 2560.503-1(g)(1)(iv) requires the Plan's limitations period to be disclosed in the final benefits determination notice, the circuit courts disagree as to whether its exclusion would still render the notice

162. Wilson v. Standard Ins. Co., 613 F. App'x 841, 843 (11th Cir. 2015).

163. *Id*. at 844.

164. *Appendix C: Model Notices*, DEP'T OF LAB., 137, 145-49, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf [http://perma.cc/7FCG-RU73] (last updated July 3, 2014).

165. *Id.* at 148.

166. DEIRDRE C. THOMAS ET AL., *supra* note 15, at 1004.

within substantial compliance of the statute. Both the interim rules and the final rules require strict compliance with the statute, except that:

> *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer.[167]

Thus, the question becomes: is the exclusion of the Plan-set limitations period prejudicial to or likely to be prejudicial to the claimant? A claimant who is in the unfortunate position of appealing after the limitations period has expired has certainly incurred harm, in the form of the costs involved in the appeals process, as well as the potential for having lost all opportunity for appeal.

If, then, the exclusion causes harm or prejudice to the claimant, did the Plan do so for good cause or for reasons beyond its control? Note especially that the requirement is not for good *faith* but for good *cause*.[168] A Plan might have a good faith belief that the final determination notice need not include the limitations period. This will not suffice. What is required is a good reason, possibly outside of the control of the Plan, to deviate from the required disclosures.[169] Finally, this reason must have been in the context of "[a]n ongoing, good faith exchange of information."[170] Only in the exchange of information is the good faith standard applied, and it requires that the Plan not withhold pertinent information from the claimant. The limitations period set in the Plan is pertinent information to the claimant's appeal.

If the Plan is not in strict compliance with the statute and does not meet the exception, the remedy is to deem the Plan's review process exhausted and allow the claimant to pursue remedies under § 502(a) of ERISA or in state court.[171] Unfortunately, in a situation where the claimant is not provided notice of the time limitations for bringing suit, this remedy puts the cart before the horse. A claimant in this situation has

167. Internal claims and appeals and external review processes, 29 C.F.R. § 2590-2719(F)(2) (2018).

168. DEIRDRE C. THOMAS ET AL., *supra* note 15, at 1007.

169. *Id*. at 931.

170. 29 C.F.R. § 2590-2719(F)(2).

171. *Id.* § 2590-2719(F)(1).

already been barred from bringing suit because the limitations period has run. The decisions in *Moyer* and *Santana-Diaz* remedy this issue.

The *Moyer* court found that failure to comply with the limitations disclosure requirements of the statute would not be found "substantial" under a substantial compliance test.[172] The dissent proposed a different substantial compliance test method that bypasses the requirements in 29 C.F.R. § 2560.503-1(g)(1)(iv), instead looking to the greater purpose of 29 U.S.C. § 1133 as a whole:

> Under our test, "[i]f the communications between the administrator and participant as a whole fulfill the twin purposes of § 1133, the administrator's decision will be upheld even where the particular communication does not meet those requirements." The "twin purposes" of § 1133 are "(1) to notify the claimant of the *specific* reasons for a claim denial, and (2) to provide the claimant an opportunity to have that decision reviewed *by the fiduciary*."[173]

In evaluating the substantial compliance analysis, the Sixth Circuit considered the purpose of the statute, namely, "that the claimant be notified of the reasons for the denial of the claim and have a fair opportunity for review."[174] The dissent argued that this review is only assured as it relates to the Plan fiduciary, citing the "twin purposes" of § 1133 cited in *Wenner v. Sun Life Assurance Co. of Canada.*[175] The majority in *Moyer* limits *Wenner* to its facts: "The adverse benefit determination letter failed to provide the plaintiff information on his right to have the benefit decision reviewed by the named fiduciary. It does not discount the statutory and regulatory language that applies to judicial review."[176] Certainly the rule-makers did not write the requirements in 29 C.F.R. § 2560.503-1(g)(1)(iv) and emphasize them again with the inclusion of 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E) for them to be set aside, even under the guise of looking to the greater purpose of 29 U.S.C. § 1133 as a whole.

In a Benefits Claims Procedure Regulations FAQs publication, the DOL has addressed the issue of substantial compliance with the application of 29 C.F.R. § 2560.503-1 requirements and suggests a remedy that would correct the harm caused by the noncompliance. First,

172. Moyer v. Metropo. Life Ins. Co., 762 F.3d 503, 506 (6th Cir. 2014).

173. *Id*. at 509 (Cook, J., dissenting) (internal citations omitted) (quoting Wenner v. Sun Life Assurance Co. of Canada, 482 F.3d 878, 882 (6th Cir. 2007).

174. *Id*. at 506 (majority opinion) (quoting Kent v. United of Omaha Life Ins. Co., 96 F.3d 803, 807 (6th Cir. 1996)).

175. *Id*.; Wenner v. Sun Life Assurance Co. of Canada, 482 F.3d 878, 882 (6th Cir. 2007).

176. *Moyer*. 762 F.3d. at 506.

the FAQs emphasize that the claimant still bears the burden of proving that the Plan failed to follow or establish claims procedures that comply with the regulations.[177] The DOL also acknowledged that the Plan has significant discretion in establishing and following procedures:

> For example, paragraph (b)(3) of the regulation prohibits a plan from establishing or administering its procedures so as to unduly inhibit or hamper the initiation or processing of claims for benefits. Accordingly, a plan will be accorded significant deference in evaluating whether it failed to follow a procedure consistent with those aspects of the regulation.[178]

The DOL also noted that "not every deviation by a plan from the requirements of the regulation justifies proceeding directly to court."[179] Inadvertent deviances from the Plan's established procedures, for example, do not trigger the 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F) "deemed exhausted" clause.[180] Instead, "if the plan's procedures provide an opportunity to effectively remedy the inadvertent deviation without prejudice to the claimant, through the internal appeal process or otherwise, then there ordinarily will not have been a failure to establish or follow reasonable procedures as contemplated by 29 C.F.R. § 2560.503-1(l)."[181] The FAQs give an example of an adverse benefit determination that, though otherwise compliant, inadvertently fails to include the specific Plan provision on which the denial was based, suggesting that this may be corrected by disclosing the missing information.[182] Such forgiveness is acceptable only when the Plan sufficiently provides access to a reasonable and compliant claims procedure.[183] This makes sense; failing to provide a specific Plan provision may inconvenience a claimant who wishes to file a claim but does not have the critical information regarding *how* to file a claim.

The FAQs continue on, explaining that consistent deviations from Plan procedures or "[d]eviations not susceptible to meaningful correction

177. *Benefit Claims Procedure Regulation FAQs, F-2: What principles are likely to be applied when a claimant elects to abandon the plan's administrative claims process in favor of pursuing his or her benefit claim in court?*, U.S. DEP'T OF LAB., EMP. BENEFITS SEC. ADMIN., https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation [http://perma.cc/JKX5-LMZD] (last visited Apr. 4, 2018).

178. *Id*.

179. *Id*.

180. *Id*.

181. *Id*.

182. *Id.*

183. *Id*. (stating that forgiveness for non-compliance is only acceptable when "the plan will have provided access to a reasonable claims procedure consistent with the regulations").

through plan procedures" justifies the conclusion that the plan does not provide reasonable procedures.[184] The FAQs then expressly exclude such remedies in certain situations, "[s]uch as the failure to include a description of the plan's review procedures in a notice of an adverse benefit determination."[185] This suggests that leaving out the time-limit of the Plan's review procedures is not easily remedied. Indeed, the time-period is a necessary part of the Plan's review procedures. A claimant unfamiliar with a claims appeal is not likely to be aware of the existence of a time limitation without being expressly told. It would not be "susceptible to meaningful correction through plan procedures"[186] unless the Plan itself directly extended the limitations period. This, however, is unlikely to happen, even aside from the Plan Administrator's potential bias toward the employer, simply because of the inherent problems with the inconsistencies of applying Plan procedures differently to diverse Participants. Such inconsistencies can lead to additional liabilities for the employer.[187]

C. Actual Notice and Constructive Knowledge

If the FAQ deviation forgiveness is applied to the omission of the Plan's limitations period, the issue could be resolved if the claimant gains actual knowledge of the Plan's limitations period. Indeed, some courts have held that knowledge of the limitations period prevents claimants from arguing the limitations period should be waived or tolled if the limitations period is not included in the adverse benefits determination.[188]

The Ninth Circuit argued that ERISA's central policy goal, protecting participants "by requiring the disclosure and reporting to participants and beneficiaries of financial and other information . . . and by providing for appropriate remedies, sanctions, and ready access to the [f]ederal courts," is satisfied by the distribution of the SPD.[189] Additionally, 29 C.F.R. § 2520.102-3(m)(4)(s) requires the disclosure of applicable time limits for claims benefits.[190] Thus, the Ninth Circuit

184. *Id*.

185. *Id*.

186. *Id.*

187. *See* Harris v. Pullman Standard, Inc., 809 F.2d 1495, 1499 (11th Cir. 1987) (finding employer's inconsistent application of plan provisions contributed to the determination that a denial of benefits was arbitrary and capricious).

188. *See supra* note 8.

189. Congressional findings and declaration of policy, 29 U.S.C.S. § 1001(b) (LEXIS through Pub L. No. 115-140); Scharff v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899, 904 (9th Cir. 2009).

190. Contents of summary plan description, 29 C.F.R. § 2520.102-3(m)(4)(s).

imputed the claimant with constructive knowledge of the limitations period because that information was in the SPD that she received prior to her claim, even if the notice was not provided in the determination notice.[191]

The Ninth Circuit, also cites cases in the Fifth, Sixth, Eighth, and Eleventh Circuit Courts finding that: "[p]lan participants who have been provided with an SPD are charged with constructive knowledge of the contents of the document." [192] All four of these cases, however, were decided and cited prior to the change in disclosure requirements of 2002, as discussed above in *Engleson*. Ironically, the *Scharff* court cited the need for uniformity amongst the circuit courts as the reason for finding receipt of the SPD equates to constructive knowledge.[193]

In *Wilson*, the Eleventh Circuit held that "there is no equitable tolling when 'the plaintiffs had notice sufficient to prompt them to investigate and . . . had they done so diligently, they would have discovered the basis for their claims.'"[194] Presumably, when the Eleventh Circuit uses the word "investigate," it refers to the expectation that a claimant will request and read the applicable SPD. It is unfair, however, to punish claimants who may not know to request the appropriate documentation and apply it to their claims, while the Plan Administrator knows the applicable limitations period and fails to disclose it as required in the regulation.

Importantly, there are significant differences between the SPD and an adverse benefits determination notice. First, the SPD may be received years before the initial claim is even brought. Second, the SPD is often a lengthy document, easily 50 or more pages, while a benefits determination is only several pages.[195] Third, the benefits determination contains only information relevant to the particular benefit claim, while the SPD summarizes the entirety of the Plan Document.[196] Thus, the claimant may not have actual notice of the limitations period at all, despite receipt of the SPD. This hardly furthers ERISA's goal of fairness to the participant. The need to punish non-compliant Plan Administrators must be balanced against the need to prevent participants from taking advantage of the non-compliance despite clear (actual) knowledge of the statute of limitations period.

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191. *Scharff*, 581 F.3d at 908.

192. *Id*. ("The Fifth and Eighth Circuits specifically declined to require plan administrators to inform participants separately of provisions already contained in the SPD.").

193. *Id.*

194. Wilson v. Standard Ins. Co., 613 F. App'x 841, 845 (11th Cir. 2015) (quoting Pac. Harbor Capital, Inc. v. Barnett Bank, N.A., 252 F.3d 1246, 1252 (11th Cir. 2001)).

195. *See* DEP'T OF LAB., *supra* note 164, at 143-44.

196. *See id.*

D. Equitable Tolling

Claimants in *Mirza, Santana-Diaz, Moyer, Wilson,* and *Heimeshoff* all pled for equitable tolling.[197] Even prior to the expanded review process rules, courts have long held that inadequate notice to claimants will toll the running of the appeals period.[198] However, the circuit courts were divided on the application of equitable tolling, even after the Supreme Court ruled in *Heimeshoff (2013).* The Supreme Court found that a Plan's limitations provision must be enforced as written unless it determines either that the period is unreasonably short, or that a controlling statute prevents the limitations provision from taking effect.[199] The Supreme Court noted that "[t]his focus on the written terms of the plan is the linchpin of 'a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'"[200]

After the Supreme Court's decision, the Eleventh Circuit in *Wilson* applied equitable tolling to Wilson's claim but held that she did not meet the extraordinary circumstances and exercise of diligence required for equitable tolling.[201] In *Wilson*, the claimant brought suit 34 months after the Plan's three-year limitations period ran out.[202] In its holding, the Eleventh Circuit cited the policy behind the Supreme Court ruling in *Heimeshoff (2013)*: "The principle that contractual limitations provisions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA plan. The plan, in short, is at the center of ERISA."[203] The Eleventh Circuit views the claimants only other option as equitable tolling, which this court calls "a form of extraordinary relief that courts have extended only sparingly"[204] and requires a showing of "extraordinary circumstances and diligence in pursuing her rights."[205]

Also, after the Supreme Court's decision, *Mirza* and *Santana-Diaz* held that equitable tolling does not apply because of the noncompliance

197. *See generally* Mirza v. Ins. Adm'rs of Am., Inc., 800 F.3d 129 (3d Cir. 2015); Santana-Díaz v. Metro. Life Ins. Co., 816 F.3d 172 (1st Cir. 2016); Moyer v. Metro. Life Ins. Co., 762 F.3d 503 (6th Cir. 2014); Wilson v. Standard Ins. Co., 613 F. App'x 841 (11th Cir. 2015); Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604 (2013).

198. DEIRDRE C. THOMAS ET AL., *supra* note 15, at 935.

199. *Heimeshoff*, 134 S. Ct. at 612.

200. *Id.* (citing Varity Corp. v. Howe, 516 U.S. 489, 497 (1996)).

201. *Wilson*, 613 F. App'x at 845-46.

202. *Id.* at 845.

203. *Id.* at 844 (quoting *Heimeshoff*, 134 S. Ct. at 611-12).

204. *Id.* (citing Bhd. of Locomotive Eng'rs & Trainmen v. CSX Transp., Inc., 522 F.3d 1190, 1197 (11th Cir. 2008)).

205. *Id.*

with the disclosure of the Plan's limitation periods.[206] Thus, the claimants were not required to show extraordinary circumstances and diligence in pursuing their rights, as the Supreme Court held.[207] Instead of tolling the limitations period, the courts simply disregarded the Plan's limitations period, as if the Plan had waived the courts' right to determine it by failing to disclose it, and instead treated the claim as if the Plan did not provide a limitations period.[208] Since ERISA itself does not provide a limitations period for bringing claims, these two courts followed the most closely analogous state law cause of action limitations period, usually contract law.[209]

E. Policy Reasons

In *Mirza,* the Third Circuit disagreed with the district court, arguing:

> If we allowed plan administrators in these circumstances to respond to untimely suits by arguing that claimants were either on notice of the contractual deadline or otherwise failed to exercise reasonable diligence, plan administrators would have no reason at all to comply with their obligation to include contractual time limits for judicial review in benefit denial letters.[210]

The Third Circuit agrees that the notices' deficiencies effectively triggered equitable tolling and, for policy reasons, found that it would be better to set aside the Plan's limitations period and instead apply the most closely analogous state law. The court's policy argument is that:

> [t]he Department of Labor obviously thought it important to make sure claimants were aware of these substantially reduced limitations periods. One very simple solution, which imposes a trivial burden on plan administrators, is to require them to inform claimants of deadlines for

206. Mirza v. Ins. Adm'rs of America, Inc., 800 F.3d 129, 133 (3d Cir. 2015) ("We do not find equitable tolling to be an obstacle, or even relevant, to Mirza's claim. Instead, we focus our analysis on . . . whether Defendants violated their regulatory obligations by failing to include the plan-imposed one-year time limit for seeking judicial review in the letter denying Mirza's request for benefits. We do so because that issue—and not equitable tolling—controls."); Santana-Díaz v. Metro. Life Ins. Co., 816 F.3d 172, 183 (1st Cir. 2016) ("Our review today, however, does not reach the equitable tolling question because we conclude that MetLife's failure to include the time limit in the final denial letter rendered, as a matter of law, the contractual three-year limitations period altogether inapplicable.").

207. Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S.Ct. 604, 615 (2013) ("[T]o the extent the participant has diligently pursued both internal review and judicial review but was prevented from filing suit by extraordinary circumstances, equitable tolling may apply.").

208. *Mirza*, 800 F.3d at 133; *Santana-Díaz*, 816 F.3d at 185.

209. *Mirza*, 800 F.3d at 133; *Santana-Díaz*, 816 F.3d at 185.

210. *Mirza*, 800 F.3d at 133.

> judicial review in the documents claimants are most likely to read—adverse benefit determinations. Section 2560.503-1(g)(1)(iv) does just that.[211]

Otherwise, "plan administrators could easily hide the ball and obstruct access to the courts."[212]

Furthermore, there is very little burden on the Plan Administrator, and great benefit to the claimant, to simply add a sentence to an adverse determination notice setting forth the time limit. The Plan Administrator, as the creator and administrator of the rules, is in a better position to know about this information. Indeed, the Plan sets forth the rules that the claimant is contractually obligated to follow with no input from the claimant. The Plan Administrator, however, is responsible for the administration of the Plan, including the internal review process. As such, it benefits the Plan if the claimant misses the limitations period.

V. CONCLUSION: ERISA'S NOTICE REQUIREMENT REQUIRES DISCLOSURE OF PLAN PROVIDED LIMITATIONS PERIOD

Without reading superfluous words into the language of 29 C.F.R. § 2560.503-1(g)(1)(iv), the meaning of the text is clear: the Plan-provided limitations period must be included in a final adverse benefits determination notice.[213] This is consistent with the intent of ERISA[214] and confirmed by the additional requirements of the PPACA.[215] Furthermore, imputing the claimant with knowledge of the limitations period based upon receipt of the SPD is unfair to the claimant, and enables Plan Administrators to bury pertinent information in massive, esoteric Plan Documents or lengthy, forgotten SPDs. The inclusion of such language is a minimal burden to Plan Administrators, who readily have the information available and know of its existence, relevance, and importance.

To avoid the equitable tolling requirement of showing either the claimants exercised diligence in pursuing their claims, or their extraordinary circumstances preventing them from doing so, in situations of noncompliance the court should set aside the Plan's limitations period and apply the limitations period of the most closely analogous state cause of action's limitations period. This is a fair solution: the claimant has

211. *Id*. at 136.
212. *Id*. at 135.
213. *See supra* notes 144-53 and accompanying text.
214. *See supra* note 13 and accompanying text.
215. *See supra* notes 22, 36-38, 144 and accompanying text.

actual knowledge of the limitations-period[216] and the employer is penalized for, at best, not complying with the statutory requirements or, at worst, intentionally hiding relevant information from a claimant. Furthermore, the limitations period is not indefinite and is based on a reasonably similar standard.[217] Barring claimants from bringing claims after the Plan's contractual limitations period have run, when the claimants were not provided the statutorily-required notice, discourages Plans' compliance with ERISA.[218]

For the foregoing reasons, the First, Third, and Sixth Circuit Courts' interpretation of 29 C.F.R. § 2560.503-1(g)(1) is most consistent with the purpose of ERISA and text of the statute. These three circuit courts' decisions to apply the limitations period from the most closely analogous state law claim when notice is inadequate is the fairest solution and encourages Plans to comply with the requirements of ERISA.

216. *See supra* notes 188-90 and accompanying text.
217. *See supra* notes 5-9 and accompanying text.
218. *See supra* note 212 and accompanying text.